

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, October 18, 2006

Members in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Andrea Arena, MD; Stanley Block, MD; Mark Braun, MD; Fadya ElRayess, MD, MPH; Sarah Fessler, MD; Michael Fine, MD; Arnold Goldberg, MD; Victor Lerish, MD; Raymond Maxim, MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Associates/Guests:* Susanne Campbell, RN; Celia Gomes-McGillivray, RN, MPH, CHES. *HEALTH:* Becky Bessette; Carrie Bridges, MPH; Ana Novais, MA; Susan Shepardson. *PCPAC Staff:* Carla Lundquist.

Unable to Attend: Gregory Allen, DO; Gowri Anandarajah, MD; Munawar Azam, MD; Solmaz Behtash, MD; L. Anthony Cirillo, MD; Robert Crausman, MD, MMS; Charles Eaton, MD; Paul George, MD; David Gifford, MD, MPH; Ellen Gurney, MD; William Hollinshead, MD, MPH; Sharon Marable, MD, MPH; Donya Powers, MD; Renee Rulin, MD, MPH; Mark Schwager, MD.

Dr. Borkan called the meeting to order at 7:40 AM. Minutes of the September 20, 2006 meeting were approved as written and the advisory letters from the September meeting were accepted with two changes: also addressing the letter to Dr. Ellen Nelson, AAG Co-Chair, and putting the conclusion in bold font (motion by Dr. Wagner, second by Dr. Block, all in favor).

❖ Ms. Novais spoke to the committee about 2006 National Primary Care Week (October 15-21, 2006) theme “Addressing Health Disparities: Healing the Nation,” focusing on **the social injustice of racial, ethnic, and socioeconomic disparities in health status and health care**. She outlined the changes made at HEALTH in the past six months to better implement strategies and recommendations to eliminate disparities across all programs and divisions, including the formation of the Division of Community Health and Equity. Most important is the department-wide effort to employ National Standards for Culturally and Linguistically Appropriate Services (CLAS), as mandated by the federal government. On behalf of the Division, and the Office of Primary Care, Ms. Novais presented PCPAC members with copies of the Institute of Medicine report “Unequal Treatment” and urged the physicians to read and use this resource tool in their practices and in their advisory role.

Ms. Campbell asked if the efforts at HEALTH to coordinate programs could address the issue of data collection forms. Community health centers and other health care sites that participate in HEALTH-sponsored programs are obligated to require new patients to fill out data collection forms for each program, in some cases four or more, frequently with redundant questions. Combining all questions into one form would be very helpful both at the site level and the patient care level. Dr. Block mentioned that some questions on the HIV forms, particularly those involving sexual histories or practices, are regarded as highly intrusive and offensive to certain cultures, causing a number of patients to decline to participate. Ms. Novais noted that diverse HEALTH programs fund community-based organizations independently and may have different data collection cycles, forms, and reporting requirements. Efforts are in development to align programs and consolidate reporting forms, and she will bring these matters to HEALTH’s data group. PCPAC members recommended that **HEALTH patient data collection forms be reviewed and simplified or consolidated to reduce redundancies**; if possible, individual forms should be eliminated altogether in favor of a single multi-program document. Questions should be re-evaluated for cultural sensitivity, and modified appropriately. To promote ease of submission, use with electronic health records, and reduction of data entry, HEALTH should mandate that all forms be eligible for electronic submission as the opportunity presents itself. The Committee urged HEALTH to pursue a coordinated data collection system that ultimately could be accessed at the point of enrollment/point of care via a single web site.

❖ Ms. Bessette, Immunization Program, updated the committee on the **availability and delivery status of flu vaccine in RI**. There is expected to be sufficient vaccine this year, but it is being released in waves and coming later than anticipated. The CDC will look into perceptions that vaccine clinics or some types of providers are getting vaccine before individual PCPs, and has advised that states and providers should plan on later distribution of vaccine in future years, for a vaccination season of October-December. The RI Immunization Program is trying to promote use of FluMist for eligible children, and anticipates receiving half of the injectable pediatric doses ordered by the end of October. Dr. Fine pointed out that insurers will reimburse for FluMist for pediatric patients, but not for adults since the injectable vaccine is cheaper and putatively available; the Immunization Program will follow up on this. CDC did not recommend prioritization or tiering this year. Dr. Lerish commented that some practices thought the survey of providers early in the season was their order, and may not realize that they need to request pediatric flu vaccine on their monthly order, as this is a new procedure. Ms. Bessette will send out clarification to providers immediately.

Dr. Fine remarked that the recent statements by the media regarding accessibility of flu vaccine in the state, and resultant frustration among providers who had not yet received any doses and confusion among their patients, underscores an opportunity to improve communications regarding vaccine to both providers and the public. Physician practices put a tremendous amount of time and effort into plans to get their patient populations immunized, and are put in a bad position when the public is hearing there is plenty of vaccine, but practices don’t have it and must scramble to reschedule clinics and persuade vulnerable patients to come back in again for vaccination. The media and the public may not focus on the fact that pediatric and adult vaccines are separate issues; therefore, public statements regarding vaccine must be consistent and equally applicable to the pediatric and adult populations. Health care providers and the public should receive the same

messages regarding availability. Public health education messages promoting flu immunization prior to the availability of vaccine in physician offices should emphasize that patients should contact their provider once public health authorities announce that sufficient doses are in providers' hands.

The Immunization Program is working on **plans for the purchase and distribution of adult flu vaccine for the 2007-2008 season** (estimated need: ~ 250K doses), and is trying to identify physician practices that administer vaccine by working with insurers, claims data, and the OSAIC purchasing cooperative. Dr. Braun suggested going back at least two years for claims data due to the problems last year, and Ms. Gomes-McGillivray reminded HEALTH to plan for the uninsured population.

❖ Dr. Sweeney updated the Committee on the CDC, ACOG, ACIP, and FDA recommendations for the quadravalent **Human Papillomavirus (HPV) Vaccine** (Merck) approved in June 2006. Vaccination is recommended for girls ages 11-12 and all women aged ≤ 26 years who have not completed the vaccine series (women over 26 years were not included in the studies). It may be administered to girls as young as age 9 at the physician's discretion. The course consists of three doses (initial, 2 months, & 6 months) at a cost of \$360. The drug is Category B, but is not recommended during pregnancy, possibly due to limitations of the studies conducted. The vaccine will provide protection against the HPV genotypes (6, 11, 16, 18) that cause 70% of cervical cancers and 90% of genital warts, unless the patient was previously exposed to these genotypes. Approval of a bivalent HPV Vaccine (genotypes 16, 18) from GSK is anticipated in June 2007; it may have a slightly longer period of protection than the quadravalent vaccine. It is not yet known if the quadravalent vaccine will require a booster. It is important to note that the HPV Vaccine does not eliminate the need for periodic cervical screening.

Currently, BCBS and United provide reimbursement for HPV Vaccine for both adults and children, pending incorporation into the Vaccines for Children (VFC) program for Medicaid and uninsured children. It is not known if NHP intends to cover the HPV Vaccine; PCPAC staff will follow up. Once part of VFC, HEALTH will purchase quantities for the entire state using funds prepaid by insurance companies and CDC monies. At present, practices providing the vaccine must pay for it up front, a considerable expense at \$120 per dose, and supplies are limited. There is every indication that VFC will cover HPV Vaccine, but the Immunization Program is waiting for a contract to be negotiated. Preliminary plans are to provide vaccine for 11-12 year olds and catch-up for older children in the program (under age 19). The initial uptake is estimated to be ~25%. The three-dose structure presents a challenge for catch-up vaccinations in assuring that the final dose is administered before children age out of the VFC program. Ms. Novais pointed out that once established, HPV Vaccine could be integrated into the "Vaccinate Before You Graduate" program. Ms. Bessette noted that the dosage spacing might require some vaccine administration in the summer. Dr. Sweeney reported that limited studies on patients who received the third dose as much as a year after the initial dose showed good immunity levels when tested six months later, so as long as the final dose is administered within that period, the course would not have to be started over. Family Medicine and Pediatric MDs will most likely administer the vaccine, since Gynecologists are less accustomed to providing vaccinations, especially for younger teens, although VFC has been approached by a number of gynecologist offices interested in participating in the program.

A few states are looking at mandating HPV Vaccine for middle school entry, but PCPAC agreed that there are a number of important issues for discussion by a broad range of stakeholders before such a proposal should be made, including:

- The need to balance the funding for primary care and for pharmaceuticals; at \$360 per patient, the cost of the vaccine is twice the annual cost of primary care. Cervical screening recommendations have not changed, so compensatory savings will not be realized on PAP smears. Cost/benefit analysis of the vaccine would be helpful.
- The debate on whether boys (as potential HPV carriers) should be immunized as well as girls, which would further limit transmission and infection, but would double costs. Consequences of HPV infection in men should be evaluated; a statewide immunization requirement may be less controversial if it applied to middle school students of both sexes.
- The safety of the vaccine, if the cost is predicted to come down, and the anticipated availability (currently limited).

The committee felt that the state should use this opportunity to look ahead and engage in a thoughtful public debate about the advantages and trade-offs of a vaccine spending choice that has profit advantages for some individuals/entities and cost discriminators for others, especially since most public communications about the vaccine thus far have been from pharmaceutical companies. To this end, PCPAC will **consider sponsoring a public forum for HPV Vaccine discussion**, possibly a CME event with an invitation to the health care community as a whole. Ms. Novais reported that a small committee at HEALTH has met with representatives of Women & Infants Hospital at their request to strategize on promotion, distribution, and addressing the implications of the HPV Vaccine. She invited PCPAC to send a representative to future meetings; Dr. Sweeney agreed to participate.

NEXT PCPAC MEETING WEDNESDAY, NOVEMBER 15, 2006